



COMMISSION TO ELIMINATE  
CHILD ABUSE AND NEGLECT FATALITIES

*NOTE: This chapter will be preceded by the Wichita story.*

## CHAPTER 2: COLLECTIVE RESPONSIBILITY FOR SAFETY

The first core component of the Commission's National Strategy recognizes that CPS agencies cannot continue to carry sole responsibility for preventing child abuse and neglect fatalities. Almost all parents and caregivers who kill their children are known to one or more professionals or agencies, but not necessarily to CPS. Relying on CPS alone to prevent these deaths is insufficient and impractical. Ensuring child safety requires involvement by the many public and private institutions that already support children and families most at risk. A safety-focused approach must be proactive, engage multiple sectors of the community, and prioritize families at greatest risk, especially those with children under age 4.

This collective approach requires a web of formal and informal supports wrapped around children and families at risk. This responsibility must be shared among many sectors of the community, including social service agencies, health care and early education providers, and law enforcement, as well as community and faith-based organizations—all working together toward the common goal of preventing deaths from child abuse and neglect. Preventing fatalities must become something that all in this web work for every day to ensure that not one more child falls through the cracks. We see CPS's role as central to this strategy, but CPS cannot do it alone.

Collective responsibility for child safety is more than another call for collaboration—it requires a fundamental shift in how we protect children, one that includes stronger CPS agencies and a transformed approach to child safety beyond CPS. This approach is not intended to diffuse responsibility; rather, we envision a more accountable and effective safety net comprised of a network of public agencies and public-private partners with clear roles and responsibilities. Building on existing policies, CPS would serve as the central governing agency of this network and work across agencies to meet children's safety goals, including the explicit goal of preventing child abuse and neglect fatalities. Achieving these changes will necessitate action at the federal, state, and local levels, building the policy and programmatic infrastructure for greater accountability, alignment, and action.

### WHAT WE LEARNED

The call for collective responsibility was one of the most resounding themes from the Commission's hearings and submitted testimony. Again and again, we were told that the solution to the crisis of child abuse and neglect fatalities cannot rest with CPS alone but

requires a response that is multisector, comprehensive, and proactive. This recommendation came from testimony by child welfare leaders, families, and experts in nearly every discipline.

The impact of a collective response was a common thread among some of the most promising efforts we saw in our travels around the country:

- Wichita’s collective impact model, highlighted earlier, provides one comprehensive model.
- New York City’s Children’s Cabinet, created in response to the death of 4-year-old Myls Dobson, brought together 24 city agencies (including child welfare) to bolster communication and develop a more holistic approach to child safety and well-being.
- Sacramento’s Steering Committee on Reduction of African American Child Deaths developed a data-driven, collective impact strategy to reduce child deaths by focusing on the neighborhoods with the highest fatality rates.

Common to each of these efforts is a broad set of stakeholders, including but not limited to CPS, driving change beyond CPS with a strong focus on prevention.

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### Getting Help From Neighbors

Sometimes families may not come in contact with CPS agencies or other formal systems, but they do have neighbors and relatives who are likely to be aware of their need for help. In New York City, three young and very disturbed mothers dropped their infants from apartment windows during a 3-month period in 2015. None of these mothers had a previous history with the city’s child welfare agency. Mayor Bill de Blasio and his wife, Chirlane McCray, issued a statement calling on New Yorkers to identify and seek help for families like these. “We can’t help someone we don’t know about,” they said. “We must learn to pick up the phone and seek help for a neighbor or relative struggling with depression or any other mental disorder.”

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More specifically, key lessons from the Commission’s travels that guide our call to action include the following:

- In nearly every case of a child abuse or neglect fatality, the child or the child’s family was known to *someone* who was in a position to help, whether that person worked for CPS or another public agency, including law enforcement and health care.
- Stakeholders both within and beyond CPS consistently asked for more resources for prevention and early intervention services. Common requests included more flexible federal and state funding streams, more opportunities to braid siloed funding lines, and policy changes to better align state and local resources.
- A key element of promising models was the engagement of health care and public health agencies as key partners. Medical personnel may be the only professionals who regularly see very young infants at risk of fatality.

- We need a clearer focus on a shared national goal of child safety by better aligning resources, policies, and programs across federal and state governments. For example, efforts should be made to better coordinate federal programs that share common goals of child health, safety, and well-being. Of particular note was the need for alignment with efforts to address other preventable child fatalities, especially post-neonatal infant mortality.
- CAPTA, the Child Abuse Prevention and Treatment Act, serves as our nation's central policy framework focused on preventing child abuse and neglect. Our Commission heard, as prior commissions and experts have noted, that the existing governance structure and public resources associated with CAPTA are insufficient to achieve its desired results. Examples of significant gaps between policy and practice can be seen in the uneven implementation of CAPTA's Plans of Safe Care, as well as in its unclear policies around what information CPS agencies must disclose to the public in the event of a death due to child abuse or neglect.

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### The Critical Role of Health Care

Health care professionals are key partners in ensuring the safety of children. Health care workers are mandated reporters of child abuse and neglect in all 50 states. In fact, health care is one of the few systems that reaches almost every child and family, particularly during the period of greatest vulnerability—the first few months of a child's life. Engagement with health care starts prenatally and continues through the birth of the child. This can make a difference, because more than 98 percent of births take place in a hospital.

For children born to mothers with substance abuse issues, CAPTA Plans of Safe Care can help ensure children's safety before the mother returns home from the hospital. Some hospitals conduct universal well-being assessments of parents to proactively identify their health, mental health, and social service needs. In Oregon, for example, the well-being assessment of a new mother becomes her linkage to home visitation services and expedited access to mental health care. Oregon officials see this access as critical to their strategy to prevent child deaths.

Health care continues to serve as an important touch point through an infant's first year of life. The American Academy of Pediatrics recommends that children under age 1 attend at least six well-child appointments in the first year of life. An overwhelming 95 percent of children regularly visit a health care professional for a well-child visit, and more than 60 percent meet the guideline of six visits during the first year. At these visits, health professionals often screen for risks to the child. For example, they may watch for parental mental health challenges or substance use problems, or respond to bruises or signs of potential neglect. Emergency departments are also an important frontline prevention point in identifying injuries potentially due to abuse or neglect.

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## RECOMMENDATIONS

### Federal Recommendations: Ensure Alignment and Coordinated Action

Central to the Commission’s National Strategy is a clear, coordinated, and collective focus on child safety. This focus must be reflected in national and state-level policies and practices. To achieve this, the Commission makes the following recommendations to strengthen federal policy for child safety and the prevention of child abuse and neglect fatalities:

#### **2.1 Require the U. S. Department of Health and Human Services (HHS) to lead the development and oversight of a comprehensive national plan that articulates federal goals and specific roles for all federal agencies involved in preventing child abuse and neglect fatalities.**

HHS should lead the development of a comprehensive and coordinated national plan detailing the federal response to preventing child abuse and neglect fatalities across federal departments and agencies. The plan should be issued by the Secretary of HHS to Congress and the president and include requests for legislative changes and/or executive orders to establish the collective responsibility of federal agencies focused on the goal of child safety, specifically, the prevention of child abuse and neglect fatalities. The plan will identify a core set of federal agencies whose involvement is critical to achieving greater protection of children from fatal child abuse or neglect. Agencies expected to be included in the national plan include, but are not limited to, agencies within HHS (Centers for Medicare and Medicaid Services [CMS], the Children’s Bureau, the Health Resources and Services Administration, Centers for Disease Control and Prevention [CDC], Substance Abuse and Mental Health Services Administration [SAMHSA], and National Institutes of Health [NIH]) as well as others within the Department of Justice and the Department of Education.

A national plan is necessary to address the critical gaps that currently exist in policy and a lack of coordination that interferes with accountability and efficiency. A national plan would establish clear and measureable goals and cultivate leadership to drive reforms and action at all levels of government. Expanding responsibility for child safety beyond CPS and creating clear roles and priorities within and across public agencies that provide child and family services is essential to creating a “shared responsibility” for preventing child abuse and neglect fatalities.

[STAFF NOTE: Will need to resolve the potential discrepancy between Recommendation 2.1 and Recommendation 3.1, if an agency not within HHS is chosen as the lead for federal efforts to prevent child abuse and neglect fatalities.]

#### **2.2 Prevent child abuse and neglect fatalities through greater alignment of federal resources with the goals of child safety.**

This would require executive action by federal agencies, as well as legislative action by Congress. Federal policymakers should examine and clarify federal policies pertaining to child safety and the prevention of child abuse and neglect fatalities. A special focus should be given to policies and programs that serve vulnerable children and families, especially families with very young children. Close attention should be given to improving safety goals and measures; accountability and coordination requirements; and the collection, sharing, and use of data on factors pertinent to preventing child abuse and neglect fatalities.

Federal programs and policies proposed for clarification and alignment include the following:

- Child welfare programs: title IV-B, title IV-E, and CAPTA
- Social Services: title XX of the Social Security Act
- Public health: title V; SAMHSA; Maternal, Infant and Early Childhood Home Visiting (MIECHV); Teen Pregnancy Prevention program
- Health care: Medicaid, State Children’s Health Insurance Program (SCHIP), and Indian Health Services (IHS)
- Early education: Child Care and Development Block Grant (CCDBG)
- Disability services
- Violence prevention and justice programs: Victims of Crime Act, Victims of Child Abuse Act, Violence Against Women Act

Our current, categorical approach to funding reinforces a siloed, bifurcated approach to ensuring child safety and supporting children and families. We need our funding infrastructure and governance of policies and programs to align with our collective approach to families, recognizing that families touch multiple systems and need to be supported comprehensively. States that have made the greatest headway in addressing child abuse fatalities are those where the jurisdictions were able to combine funding from multiple categories to offer integrated services.

Building on existing national policies for child safety within child welfare programs, Congress should embed reciprocal policies that bolster child safety across key public programs. We want to strengthen CPS as the lead agency responsible for ensuring safety, supported by a more comprehensive group of agencies proactively working to strengthen its impact.

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### **Alerting Domestic Violence Professionals to Child Abuse**

Holding fast to a lens on child safety is critical for those who work with families affected by domestic violence. This includes law enforcement, as well as staff of domestic violence services programs, and of course, CPS agency staff.

Domestic violence affects children in numerous ways. They are often traumatized when the adults in their lives hurt each other. And research shows that perpetrators of domestic violence not only abuse their spouses or partners, but many also abuse the children in the home. All who answer or investigate domestic violence calls need to make sure they look out for the safety of the children as much as for the adult victims.

In testimony, the Commission heard that law enforcement, domestic violence, and child welfare agencies have critical insights to share with one another in the interest of protecting children in potentially lethal situations. Maryland and Utah have programs in which professionals use a special lethality assessment protocol at the scene of a domestic violence call. This helps to better flag children in families at risk.

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- 2.3 Through legislation, Congress should direct states to develop and implement a comprehensive state plan to prevent child maltreatment fatalities. This requirement should be included as a title IV-E state plan requirement and as a requirement in key health, public health, and justice programs to ensure the full and meaningful implementation of this action. These state child fatality prevention plans should take a comprehensive, early intervention approach, with CPS being one of multiple key partners.**

Similar to having a comprehensive national plan to prevent child abuse and neglect fatalities, every state should have a strategic plan, coordinated at higher levels of the governor's office, to prevent maltreatment fatalities. All plans should address common risk factors for child abuse and neglect fatalities, but legislation should allow states local flexibility to meet the needs of their population and build on resources already in place. States should define how they are going to reach certain core competencies or core elements and be responsible for evaluating their effectiveness. The federal government could provide some innovation money to help them test and evaluate their strategies.

Core components of state plans should include the following:

- States must create an interagency working group of senior executive department leadership. At a minimum, this working group must meet quarterly and include child welfare, public health, early childhood, law enforcement, and the courts.
- The state plan must be approved annually by the governor before being submitted to HHS.
- The state must have a plan to engage public-private partners, community organizations, and faith-based communities.
- The state must identify how it will ensure increased program alignment with upstream prevention programs to strengthen child safety, including expedited access to title V and MIECHV services.
- The plan's action strategy must be driven by data (including state needs assessments and cross-system data sharing).
- Data tracking must include the following:
  - Use of a standardized, federal definition of child abuse and neglect fatality
  - Use of a federal definition of child abuse and neglect near fatality
  - Use of three or more data sources in tracking fatalities and near fatalities
  - Identification of the ZIP codes and/or census tracts with high rates of child abuse and neglect fatalities and near fatalities

#### **State Recommendations: Implement Coordinated Action**

- 2.4 The governor and legislature of each state should convene a public-private stakeholder summit to raise awareness of child abuse and neglect fatalities and**

**identify a strategy for supporting the state plan to eliminate child abuse and neglect fatalities.**

- 2.5 The governor should designate an interagency state lead for a statewide collective impact initiative to prevent child abuse and neglect fatalities.**
- 2.6 States should be incubators of innovation in addressing new modalities for fatality prevention. This should be supported through federal innovation dollars and collaboration with public-private partners.**

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*NOTE: This chapter will be preceded by the Salt River story.*

## CHAPTER 3: ALIGNED LEADERSHIP AND ACCOUNTABILITY

The second component of the Commission’s National Strategy recognizes that a collective approach to preventing child abuse and neglect fatalities will be effective only insofar as it is implemented and evaluated with strong, central leadership and clear lines of accountability.

In order to make the changes needed to prevent child abuse and neglect fatalities, we need a new type of leadership—system leadership. System leadership brings together a diverse array of organizations and stakeholders to address a complex social problem that requires unprecedented collaboration, jointly developed solutions, and a collective shift in focus from reactive problem solving to building what is needed for the future.

Leadership drives change, defines measures of success, regularly assesses progress toward those goals, and marshals the necessary human capacity and resources to achieve results. This type of leadership will be necessary at all levels of government to ensure effective implementation and oversight of both existing and new policies and practices aimed at preventing child abuse and neglect fatalities.

Accountability is the acknowledgment and assumption of responsibility for actions, decisions, and policies. It encompasses the obligation to report, explain, and be answerable for outcomes. It is not enough to say, “Everyone is responsible for protecting children.” Someone must lead a coordinated effort, and those involved must agree to hold each other accountable for the most important outcome of all—child safety.

### WHAT WE LEARNED

In several of the communities that the Commission heard from, including Wichita, Kansas and the Salt River Pima-Maricopa Indian Community near Phoenix, Arizona, Commissioners learned firsthand the important role that leadership and accountability can play in helping to keep children safe. We witnessed great leaders who transformed systems through their vision and actions. Despite these examples of excellence, it remains a difficult task to replicate such approaches in other communities. Child protective services (CPS) systems often are overwhelmed by their immediate task of keeping children safe. In the absence of reciprocal, enforced requirements to reach out to and plan with leaders of other systems that see the same families, CPS leaders rarely have or make the time to do so.

We encountered communities where government leadership is lacking and responsibilities are blurred—not from a lack of concern over the tragic death of a child, but rather as a result of significant gaps in the policies and practices needed to cultivate a culture of leadership and accountability. We observed some common themes that may inform efforts to establish clear leadership and strengthen lines of accountability:

- There has been a lack of sustained federal leadership demanding greater attention to the issue of child abuse and neglect fatalities. Likewise, few state and local government agencies have prioritized reducing these deaths.

- There is little specific federal leadership or guidance to states and localities on how to prevent or respond to child abuse and neglect fatalities. Scant references to child abuse and neglect fatalities exist in federal policies, administrative guidance, and federally supported technical assistance and research. This lack of attention to the issue in policy guidance hinders the ability of state officials and communities to develop or implement prevention and intervention practices backed by solid research.
- Federal policy makes clear that the safety of children is a paramount concern. Congress has enacted a range of policies to help ensure the safety and health of children who are at greatest risk of harm. Yet, a close examination of safety-related policies reveals inconsistent implementation among the states and a lack of enforcement at the federal level. One federal law that has particular relevance is the Child Abuse Prevention and Treatment Act (CAPTA). It provides the federal framework for policies relating to child abuse and neglect prevention. The law, however, is considered fragmented and extremely underfunded by many in the field. It is inconsistently implemented by the states. The federal government does not provide needed guidance on implementing its requirements, nor does it monitor or enforce the required provisions. Each state interprets CAPTA differently and acts accordingly.
- There are clear expectations that the CPS agency in each state plays a central role in keeping children safe from harm. Indeed, the child protection agency is commonly the only agency held responsible for ensuring a timely investigation and response to such tragedies or preventing them in the first place. Yet, child protection agencies often lack the positioning, authority, and resources needed to ensure a reliable safety net for children most at risk of harm. Further, the child protection agency is not the only public actor with the potential to reduce or prevent child abuse and neglect fatalities. Many other agencies have a unique tie to the mission of keeping children safe (e.g., health care, law enforcement, domestic violence programs, child care, and others).
- Transparency is a critical precondition for the exercise of accountability. Without access to clear and accurate information—information that is shared among all key parties—it is impossible to determine whether performance standards are met.

## RECOMMENDATIONS

### Federal Recommendations: Elevate the Issue and Strengthen Accountability Measures

The Commission makes the following recommendations to strengthen leadership and clarify accountability at the federal government level with regard to child abuse fatalities:

#### **3.1 Elevate the issue of child abuse and neglect fatalities within the federal government.**

Currently, responsibility for preventing child abuse and neglect fatalities is dispersed throughout the federal government and shared by many agencies at the federal and state levels. It is in the best interest of children to designate a single, coordinating agency that is responsible for setting a shared agenda and facilitating data sharing among responsible agencies.

The responsibility of this lead agency would be to ensure that federal child abuse and neglect prevention and intervention efforts are coordinated, aligned, and championed to reduce

fatalities and near fatalities. It would do this by encouraging partnership among all levels of government, the private sector, philanthropic organizations, educational organizations, and community and faith-based organizations. Further, this entity would be responsible for coordinating with other key stakeholders in the relevant offices within HHS, and the Departments of Education, Justice, and Defense.

This agency would be charged with the development and execution of a comprehensive federal plan for the prevention of fatalities, as introduced in Chapter 2.

The agency would also be charged with convening a national council on the prevention of child abuse and neglect fatalities. The council will include political leadership from agencies that have a role in promoting the safety, health, and well-being of all children, including but not limited to the Maternal and Child Health Bureau within the U.S. Department of Health and Human Services (HHS), the National Institutes of Health (NIH, especially the National Institute of Child Health and Human Development), the Assistant Secretary for Planning and Evaluation at HHS, the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Indian Health Service, and the Administration on Children, Youth and Families. The council will be charged with the following:

- Establishing data-sharing protocols across agencies and producing an annual report to be issued by the lead agency to the president and Congress.
- Developing a national research agenda on child maltreatment fatalities and disseminating research knowledge and best practices to states.
- Conducting a comprehensive review of federal statutes, regulations, and administrative guidance to identify areas where federal policy can be strengthened to help prevent child maltreatment fatalities and improve overall child safety outcomes. The council will submit this report to Congress and the president. Policies and practices to be examined include, but are not limited to, titles IV-E (specifically, the Child and Family Services Reviews safety measures), IV-B, V, XI, and XX; CAPTA (including public disclosure policies); the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program; and the Public Health Act.

*Several options have been proposed by Commissioners and staff for accomplishing Recommendation 3.1. They are listed below for Commissioners' consideration:*

- A. Establish the Children's Bureau as a Cabinet-level department.** The Commission recommends establishing the Children's Bureau as a Cabinet-level department that addresses issues of child welfare, a key component of which would be child protection with a national goal of preventing fatalities and near fatalities due to abuse or neglect. The newly configured Children's Bureau would include responsibility for maternal and child health by bringing the Maternal and Child Health Bureau (MCHB) under the Children's Bureau. This would send a clear message that the safety of our children and eliminating child abuse and neglect fatalities is an unambiguous national priority that is the responsibility of both child welfare and public health agencies. It would establish that eliminating child abuse and neglect fatalities is as important as the education of our children, the nation's housing needs, fostering a secure and reliable energy system, and international trade—all issues represented by Cabinet-level agencies. *(Staff comment: This recommendation does not seem politically*

*feasible. Given the focus on reducing government, calling for an entire new agency may prove difficult. Commissioner Cramer also cautioned about creating a Cabinet-level bureaucracy.)*

- B. Elevate responsibility for preventing fatalities from the Children’s Bureau to the Administration on Children, Youth and Families.** This would bring the issue one step closer to the Assistant Secretary for the Administration for Children and Families within HHS.
- C. Create an Office of Child Safety within the Office of the Secretary of HHS.** The Office of Child Safety would be led by an Assistant Secretary of the Children’s Bureau and would be a direct report to the Secretary of HHS.
- D. Create a position responsible for child safety within the Domestic Policy Council or the Office of Management and Budget (OMB).**
- E. Assign the responsibility for preventing child abuse and neglect fatalities to the Office of the Surgeon General.** Injury and Violence Free Living is one of the Surgeon General’s seven top priorities in the National Prevention Strategy.

**3.2 Under the Government Performance and Results Act (GPRA), the Executive Branch should establish performance goals specific to the reduction of child abuse and neglect fatalities.**

GPRA has been in effect for many years, and current law requires federal agencies to set goals and targets for performance management for main function areas. At present, the Commission has found no agency that is using GPRA to drive results in the area of child abuse and neglect prevention (including prevention of fatalities and near fatalities). We therefore identify GPRA as an important policy that could be leveraged to achieve better results.

We recommend, through legislation or executive action, that the federal government—led by the Office of Management and Budget—create a federal government performance plan featuring cross-agency priority (CAP) goals and targets for improved government performance on the issue of child abuse and neglect fatalities. Under this new GPRA goal, federal agencies would work collectively and through OMB to review goals and progress on a regular basis. Performance data on this measure would be reported via a central website at [Performance.gov](http://Performance.gov).

**3.3 The Children’s Bureau should issue regulations regarding disclosure following a fatality.**

Regulations regarding the CAPTA requirement for public disclosure of findings or information about cases of child abuse or neglect that result in a child fatality or near fatality must be issued so that states are clear about what is required.

**3.4 The Children’s Bureau should add measures specific to child abuse and neglect fatalities to its Child and Family Services Reviews (CFSRs).**

The Children’s Bureau conducts the CFSRs to achieve three goals: (1) ensure conformity with federal child welfare requirements, (2) determine what is actually happening to children and

families as they are engaged in child welfare services, and (3) assist states in enhancing their capacity to help children and families achieve positive outcomes. Currently, the two indicators of safety measured by the CFSRs are recurrence of maltreatment within 6 months of a maltreatment incidence and maltreatment of children while in foster care. Clearly, collecting and reporting data about how many children served by the child welfare system died of abuse or neglect provides a critical indicator of safety.

#### **State Recommendation: Create a Task Force**

The Commission heard a great deal about the challenges faced by state and local child protection agencies in their efforts to reduce abuse and neglect fatalities. We also heard repeatedly that, while child protection agencies are critically important to this effort, they should not be seen as the only component of a sound child abuse and neglect fatality prevention strategy. Thus, the Commission offers the following recommendation to augment state governments' organizational and legislative support of a broader and better-connected safety system that can increase the probability of reducing fatalities due to abuse and neglect.

#### **3.5 Each Governor should create a permanent state task force for reducing child abuse and neglect fatalities.**

The task force should be accountable for the prioritization of child safety and coordination of agencies that share responsibility for services to vulnerable children and families. The task force should meet twice a year. The director of the state's child welfare agency should co-chair the state task force, along with the head of the state health agency. Additional state officials should have a seat on the task force, including members of the legislature, mayors, county executives, judges, as well as heads of health, public health, early childhood, child care, and law enforcement agencies. In addition, leaders from the community should be involved, including hospital administrators, faith-based leaders, and others.

The task force should be charged with developing and implementing a state plan for reducing child abuse and neglect fatalities (see recommendation 2.3). The governor-led strategy should specify how various state and county agencies will align their goals and coordinate their services to ensure a maximum focus on child safety. Each year, the task force should be required to produce a summary report on its efforts to implement the strategy, which should be submitted to the governor and state legislature. The resulting strategy should include benchmarks for reducing child abuse and neglect fatalities.

### **CONCLUSION**

No national reform, certainly not one as significant and complex as preventing child abuse or neglect deaths, will happen without good leaders. As a nation we are fortunate that our leaders at every level care about children. They know that even one death from abuse or neglect is one too many. The recommendations in this report call for leadership guidance from the federal government to empower leaders at the state and local levels to work together and hold each other accountable. The Commission is committed to giving our colleagues across the country the authority to turn the vision of a better future for all children into reality.

**NOTE:** *This chapter will be preceded by a story about Hillsborough County and Rapid Safety Feedback.*

## CHAPTER 4: DECISIONS GROUNDED IN BETTER DATA

The third core component of the Commission’s National Strategy is the development of better data about the incidence and circumstances surrounding child abuse and neglect fatalities. In order to prevent fatalities, we need a better understanding of how many children die from maltreatment and how they die.

It is impossible to prevent child abuse and neglect fatalities without knowing the extent of the problem. If we lack reliable and valid data that are uniform across states and jurisdictions from year to year, how are we to evaluate preventive actions and interventions to discover which are working (and thus deserve our continued investments) and which are not? We need data that are collected consistently over time, from year to year and jurisdiction to jurisdiction, so that we can accurately measure progress.

It is critical to further classify abuse and neglect in a way that reflects the characteristics of the victim and perpetrator, the cause of the child’s death (e.g., abuse, supervisory neglect, medical neglect, etc.), the relationship of the perpetrator to the child, and the circumstances that preceded the fatality. Finally, the collection of data on near fatalities greatly expands the available data on this problem and is critical to enhancing our understanding and prevention of fatalities.

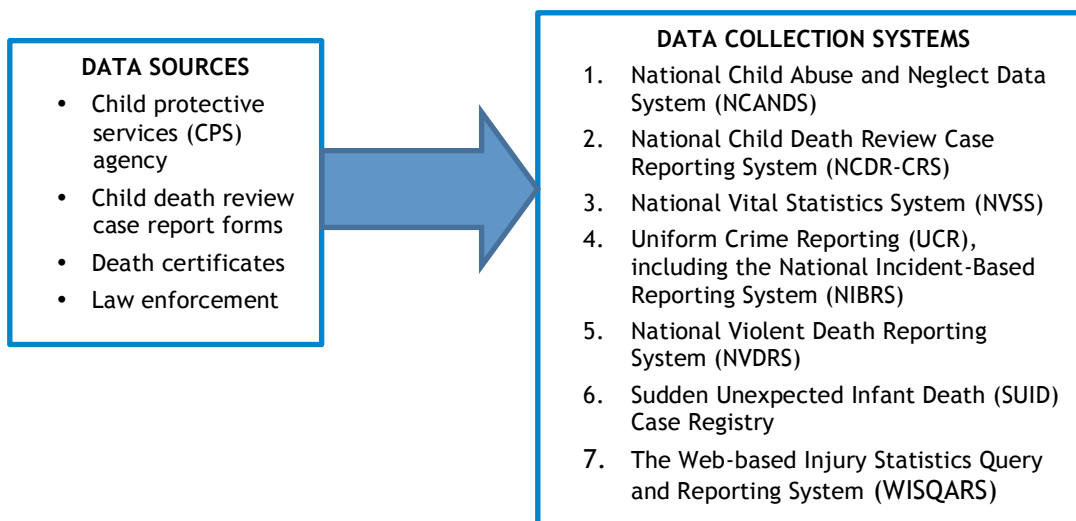
### WHAT WE LEARNED

An exhaustive review of the literature combined with testimony from a wide variety of experts—including child welfare researchers, academics, child welfare administrators, law enforcement professionals, and officials from the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Justice—provided the Commission with information about the quality and extent of the data currently collected on child abuse and neglect fatalities.

We identified a number of areas for improvement.

- The National Child Abuse and Neglect Data System (NCANDS), the official source of child abuse fatality data, has significant limitations. It primarily reflects fatalities reported to, investigated by, and substantiated as abuse or neglect by CPS agencies. If these agencies are not aware of a death, choose not to investigate it, or do not classify the death as the result of abuse or neglect, it is not counted.
- The submission of state data about abuse or neglect fatalities to NCANDS is not required; it is voluntary. All states submit data, but states do not all submit the same data in the same way.
- In addition to NCANDS, there are six other federally funded data systems that collect data on deaths due to child abuse and neglect. These systems are not linked to NCANDS, and the data are not reconciled. The primary data sources for the systems that collect information about these fatalities are described in the following chart:

### Multiple Data Sources and Collection Systems



- Determining that a child’s death is due to abuse and neglect is subject to a particular agency’s function (e.g., child welfare, district attorney offices), varying state laws and definitions, local policy and practice, and the investigators’ or reviewers’ knowledge and expertise in interpreting these variables. For example, if two children in two states die under the same circumstances, the two states may make different determinations about whether the deaths were caused by abuse or neglect. The same is true of different jurisdictions within the same state or even within the same jurisdiction in different years.
- Most agencies and professions agree on the definition of “physical abuse,” but determining if a death is due to neglect is a more complex problem. Each agency or investigator may have different views of the societal norms that draw the line between minimally adequate care or supervision and serious, life-threatening neglect.

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#### Three Deaths, Three Different Decisions/Conclusions

Three infants all died in the same state in the same year in sleep-related deaths. The first two infants died in the same county, while the third infant died in a neighboring county.

*Infant 1 was a 1-month-old infant who died while sleeping in bed with his parents and three other children. The family was previously known to CPS for domestic violence and parental illegal substance use, but there had been no referrals on the 1-month-old. Within a few days of the infant’s death, CPS required maternal drug testing, which was positive for heroin. The mother pled guilty to endangering the welfare of children and reckless endangerment. This case was not substantiated and therefore was not included in the national count.*

*Infant 2 was a 3-month-old infant who died while sleeping on his parents' bed. Both parents tested positive for heroin on the evening of the baby's death. The baby was found face down on the bed. The cause of death was suffocation. CPS determined that "no evidence was found to indicate their substance abuse impaired their decisions on the day of [the child's] death." This case was not substantiated.*

*Infant 3 was a 1-month-old who died while sleeping in his mother's bed. The mother was previously known to CPS for truancy and drug use. CPS determined that "the mother caused the victim child's death by co-sleeping while under the influence of controlled substances." This case was substantiated.*

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- NCANDS collects limited information about the circumstances under which children die due to abuse and neglect.
- Data on near fatalities are not universally collected, despite the fact that these data could help shed light on prevention of fatalities. Although we do not know exactly how many children suffer near fatalities due to child abuse and neglect, research suggests that it may be tens of thousands of children, depending on how "near fatality" is defined.

## RECOMMENDATIONS

The information above led the Commission to make four primary recommendations related to improving the ability to uniformly define child abuse and neglect fatalities, accurately count them, and obtain more comprehensive data on fatalities in order to improve prevention policies and practices.

### 4.1 Develop a national child abuse and neglect fatalities data tracking system.

This could be done by reconciling and building upon existing federally funded data collection systems. These multiple systems define child abuse and neglect fatalities differently, collect different types of data about each fatality, are not linked, and, therefore, cannot share data. Improving the quality and standardization of data and requiring that data be submitted to each of these federal databases would be key to the success of this approach. Adding a fatality/near-fatality file to NCANDS would also be an important step. Currently, there is only one question in NCANDS that asks whether the child died. There is no variable that asks whether injuries or events constitute a near fatality.

### 4.2 Develop a standardized operational definition and multidisciplinary process for identifying child abuse and neglect fatalities. **STAFF NOTE: This might be unnecessary if the Commission recommends a data-mining system similar to the one developed for the airline industry.**

This will require development, field-testing, and implementation of a uniform operationalized definition and decision tree for child abuse and neglect fatalities. The definitions should not rely on agency-specific definitions of child abuse and neglect and should be developed for the

specific purpose of counting fatalities (whether or not they meet criminal or civil definitions of abuse and neglect) so we can develop and evaluate prevention efforts. The process of determining whether a fatality is due to abuse or neglect using the standardized definition must require the use of interdisciplinary teams (e.g., child welfare, law enforcement, health care) and shared decision-making. Standardized death scene protocols also need to be developed, and states should be required to use these standardized definitions and processes.

The decision about whether a child has died from abuse or neglect occurs along a continuum of causation. There must be a uniform cutoff point at which we, as a society, decide that there is enough evidence to attribute the cause of death to abuse or neglect. Some cases may be obvious to all, such as a father who drowns his child or the parent's boyfriend or girlfriend who violently shakes a baby to death. But what if a parent leaves a 10-month-old in a bathtub to check emails, and the infant drowns? Is this neglect or a tragic accident? Does the decision change if the parent was under the influence of alcohol or drugs at the time? What if the parent had had a previous child die?

Currently, states each choose their own cutoff point. The majority of states (36 of 50) use a "preponderance standard," meaning that there must be a "preponderance of evidence" to count a death as caused by child abuse or neglect. Other states use "credible evidence," "reasonable evidence," and "substantial evidence." The terms "preponderance" and "credible" are not defined, and these terms are subjective. Kansas uses a "clear and convincing" standard, a much higher threshold than the preponderance standard. This means that a child who dies under the same circumstances in Kansas and, for instance, Massachusetts would likely be counted as a fatality due to child maltreatment in Massachusetts but not in Kansas.

It is important to recognize that most states intentionally set an evidentiary threshold for determining if a child is maltreated that is below the criminal evidence threshold of "beyond a reasonable doubt." This is appropriate, because the threshold to protect a child and connect the child and family to interventions should be below the threshold to charge an adult with a crime that could result in a prison term. So it is not unreasonable that a child may be counted as having died from child abuse or neglect in the eyes of the CPS agency, but the criminal system may not prosecute the caregiver.

#### **4.3 Collect comprehensive data about the circumstances that precede the fatality in addition to data about the circumstances of the fatality itself.**

Much more information about the circumstances and demographics of each death needs to be collected. It is also important to know the family's—not just the child's—past experience with CPS and what transpired. Previous referral to CPS is a critical variable that must be included and clearly defined. A standard set of data must be collected about each prior contact between CPS and the family. Information about the perpetrator, relationship to the child, possible substance use or mental health issues, any special needs that the child had, and other variables are all important for data analysis and for determining effective prevention strategies.

In addition to accurate counting of fatalities, more detailed information is critical for prevention. Different prevention strategies are called for depending on the characteristics of the child and perpetrator, the way in which the child dies, and the relationship of the perpetrator to the child. Potential prevention and intervention programs may be different for

children at risk for physical abuse, compared to supervisory neglect, for example, in part because different types of deaths may be more likely to be caused by certain perpetrators. Physical abuse is more likely to be perpetrated by a mother's paramour, whereas neglect is more likely to be perpetrated by a mother, in part because a mother is most often her child's primary caregiver.

Requiring more comprehensive data collection involves changes to the data collection system (e.g., NCANDS), a federal mandate to the states requiring these data fields, and perhaps, most importantly, a recognition that better data collection means allocating more time and, therefore, more money to do it right. It is not clear whether CPS systems are currently collecting, but not reporting, the data that the Commission feels are critical or whether this information is systematically collected at all.

#### **4.4 Group near fatalities with fatalities for the purposes of counting, classification, and development of prevention programs.**

Collecting and analyzing data on near fatalities can broaden the information on child abuse and neglect fatalities and help us better determine which prevention strategies are most effective. Near fatalities could be defined as part of the same process by which standardized, operational definitions for child abuse are developed.

Near fatalities—events in which a child nearly dies from child abuse and neglect—are similar to child abuse and neglect fatalities in almost every way. Statistically, children who suffer from a near fatality are almost identical in age to those who die from child abuse; their family risks factors are similar (including high prevalence of domestic violence and substance abuse), as are the relationships between perpetrators and victims.

What often differentiates a near fatality from a fatality is simply the difference in medical care received and the timing of that medical care. In other words, the only reason one child survives and another dies from the same type of abuse or neglect may be the fact that the first child lives close to a hospital that offers advanced medical care and is staffed by doctors trained to diagnose and treat life-threatening events. It is important to keep in mind that the children who survive these near-fatal events are often left with severe, lifelong disabilities.

Right now, studying near fatalities is difficult because there is no clear or universally accepted definition. CAPTA defines a near fatality as “an act that, as certified by a physician, places the child in serious or critical condition.” Many states have their own definitions of what it means for a child to be in “serious” or “critical” condition. In California, for example, a near fatality is “a severe injury or condition caused by abuse or neglect and requires that the child have received critical care for at least 24 hours following the child's admission to an intensive care unit.” In New Jersey, the definition is “a serious or critical condition certified by a physician, in which a child suffers permanent mental or physical impairment, a life threatening injury or a condition that creates the probability of death within the foreseeable future.” Because of the lack of a standardized definition, the same event might be considered a near fatality in one state but not in another, just as similar fatalities may be classified differently in different states.

As a result of this lack of standardization, and because states are not required to review or report near-fatality cases in the same way they review or report fatalities, we don't know exactly how many children suffer near fatalities from abuse or neglect every year. Several

researchers have used data from children who are hospitalized with serious injuries to try and calculate this number. Their research suggests that, for every child who dies as a result of abuse, more than 10 children are hospitalized with severe abuse- or neglect-related injuries. Given that an estimated 3,000 or more children die annually from child abuse or neglect, these data suggest that tens of thousands of children suffer near fatalities each year.

## CONCLUSION

The Commission's recommendations are intended to address the key problems of data: Data are incomplete, subjective, variable, and siloed. We do not have a data system now to help us learn from past fatalities and make the right decisions to prevent future abuse or neglect fatalities and near fatalities.

Children who die have no voice. Counting a child's death is a way to honor each child killed by a parent or caregiver and give each a voice that may change the future.